STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS
CERTIFICATE OF NEED APPLICATION FORM
FORM (2000)

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed expansion or new service will augment or replace? Please list.

Augment: |

Replace: |

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

If "No" is checked, please provide an explanation.

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4. Clear Public Need

A. Explain how it was determined there was a need for the proposal in your service area.

i) Provide the following information:
   a) Primary and secondary service area towns
   b) If existing facility/service, the unit of service (i.e. procedure, scan, visit, etc.) for the past three fiscal years by service area town
   c) If new facility/service, the number of referrals for the proposed service for the most recent fiscal year by receiving site
   d) Scheduling backlogs in service area

e) Travel distance from proposed site to service area towns
f) Hours of operation of existing/proposed service

ii) Identify the existing providers of the proposed service in your service area. What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

iii) Provide the following for the projected utilization of the proposed service:

a) The units of service projected for the first three years of operation. Include the derivation/calculation.
b) The units of service by procedure code for the first full year of operation and by unique physician identifier (e.g., Dr. A, B, C, etc.).

B. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify)

If you checked other than None of the above, please provide an explanation.

C. Provide copies of any of the following plans, studies or reports related to your proposal:

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify)

5. Quality Measures

A. Have all appropriate agencies approved the proposed service/procedure (e.g., FDA etc.)?

☐ Yes ☐ No ☐ Not Applicable

If "No", please provide an explanation.

B. Check off all the Standard of Practice Guidelines that will be utilized by the Applicant for the proposed service. Please submit the most recent copy of each report related to the proposal:

☑ American College of Cardiology	☐ National Committee for Quality Assurance	☐ Public Health Code & Federal Corollary
☐ National Association of Child Bearing Centers	☐ American College of Obstetricians & Gynecologists	☐ American College of Surgeons
☑ Report of the Inter-Society Council for Radiation Oncology	☐ American College of Radiology	☐ Other: Specify

C. Provide a brief summary of how the Applicant plans to meet the guidelines related to this proposal.

D. Submit a list of all key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), related to the proposal and a copy of their Curriculum Vitae.

***Note**:* For physicians, please provide a list of hospitals where the physicians have admitting privileges.

E. Provide a copy of the most recent inspection reports and/or certificate for your facility:

☐ DPH	☐ JCAHO
☐ Fire Marshall Report	Other States Health Dept. Reports (new out-of-state providers)
☐ AAAHC	☐ AAAASF
☐ Other: _____	

Note: Above referenced acronyms are defined below. [1]

[1] DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Ambulatory Surgery Facilities, Inc.

F. Provide a copy of the following (as applicable):

- ☐ A copy of the related Quality Assurance plan
- ☐ Protocols for service (new service only)
- ☐ Patient Selection Criteria/Intake form

6. Improvements to Productivity and Containment of Costs

In the past year has your facility undertaken any of the following activities to improve productivity and contain costs?

- ☐ Energy conservation
- ☐ Group purchasing
- ☐ Reengineering
- ☐ None of the above
- ☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)

Other (identify)

Miscellaneous

A. Will this proposal result in a change to your teaching or research responsibilities?

☐ Yes ☐ No

If you checked “Yes,” please provide an explanation.

B. Are there any characteristics of your patient/physician mix that makes your facility unique?

☐ Yes ☐ No

If you checked “Yes,” please provide an explanation.

C. Provide the following licensing information:

i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.

ii) The DPH licensure category you are seeking.

iii) If not applicable, please explain why.

D. Please provide the name of the entity that will be billing for the proposed service.

7. Affiliations, Mergers, Acquisitions and Changes in Ownership

A. Provide a copy of the written agreement or memorandum of understanding between the Applicants related to the proposal.

Note: If a final version is not available, provide a draft with an estimated date by which the final agreement will be available.

B. Identify the following items for each Applicant:

i) Geographical service area.
ii) Health care services provided.
iii) Physician referral patterns.
iv) Corporate or entity structural relationships.
v) Shared service arrangements (e.g., Group Purchasing, billing etc.).

C. Provide for each Applicant the following information related to the proposal:

i) Articles of Incorporation, Articles of Organization or Partnership Agreements (all that are appropriate).
ii) Legal chart of corporate or entity structure.
iii) Board of Directors or governing body resolutions approving the proposal.
iv) Current and proposed percentage of ownership.
v) Changes in legal status.
vi) Changes in membership of board of directors or governing body.
vii) Changes in independence of board of directors or governing body.
viii) Changes in facility licensed beds, health care services, service areas, locations and management.
ix) Medicare provider number.
x) For hospitals, please identify if a new cost center will be established or if an existing cost center will be utilized. Provide the units of service for all new cost centers.

9. Financial Information

A. Type of ownership: (Please check off all that apply)

☐ Corporation (Inc.) ☐ Limited Liability Company (LLC)

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

Provide the following financial information:

i) Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the Applicant is a hospital that has filed its most recently completed fiscal year audited financial statements, the Applicant may reference that filing for this proposal.

ii) If the Applicant is not a hospital, please submit a complete set of audited financial statements and/or an annual report for the most recently completed fiscal year, if available.

iii) If the Applicant has no audited financial statements, please submit an unaudited Balance Sheet and Income Statement or Statement of Operations for the most recently completed fiscal year. These statements should be externally prepared and submitted on the preparer's letterhead.

10. Major Cost Components/Total Capital Expenditure

Submit a final version of all capital expenditures/costs as follows:

Medical Equipment (Purchase)	$	
Imaging Equipment (Purchase)		
Non-Medical Equipment (Purchase)*		
Land/Building (Purchase)		
Construction/Renovation		
Other (Non-Construction) Specify		
Total Capital Expenditure	**$**	0.00
Medical Equipment (Lease (FMV))	$	
Imaging Equipment (Lease (FMV)		
Non-Medial Equipment (Lease (FMV))*		
Fair Market Value of Space – Capital Lease		
Total Capital Cost	**$**	0.00

Capitalized Financing Cost	
Total Capital Expenditure with Cap. Fin. Costs	$

***** Provide an itemized list of all non-medical equipment.

11. Construction Information

A. Provide a detailed description of the proposed construction/renovation including the related gross square feet of new construction/renovation.

B. Provide all schematic drawings related to the project that are available, including existing and proposed floor plans.

C. Provide a breakdown of the following construction costs:

Item Designations	New Construction	Renovation	Total Cost
Total Building Work Costs			$0.00
Total Site Work Costs			$0.00
Total Off-Site Work Costs			$0.00
Total Arch. & Eng. Costs			$0.00
Total Contingency Costs			$0.00
Inflation Adjustment			$0.00
Other (Specify)_____			$0.00
Total Construction/Renov. Cost	$0.00	$0.00	$0.00

D. Explain how the proposed construction or renovations will affect the delivery of patient care.

E. Provide the following information regarding the schedule for construction/ renovation:

Construction Commencement Date	
Construction Completion Date	
DPH Licensure Date	
Commencement of Operations Date	

12. Capital Equipment Lease/ Purchase or Land/ Building Acquisition

If the CON involves any capital equipment lease and/or purchase, please answer all of the following that apply:

1.	What is the anticipated residual value at the end of the lease or loan term?	
2.	What is the useful life of the equipment/ building?	Months
3.	Please submit a copy of the vendor quote or invoice as an attachment.	
4.	Please submit a schedule of depreciation for the acquired equipment as an attachment.	

If the CON involves any land or building acquisitions, please answer all of the following that apply:

1.	What is the useful life of the equipment/ building?	Months
2.	Please submit a schedule of depreciation for the acquired equipment as an attachment.	
3.	Please submit a copy of the property appraisal as an attachment.	

For multiple items, please attach a separate sheet for each item in the above format.

13. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicant's equity:
Source and amount:

Operating Funds	$
Contributions	$
Funded depreciation	$
Other	$

☐ Grant:

Amount of grant	$
Funding institution/ entity	

☐ Conventional loan or
☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Amount of total debt	$
Interest rate	%
Monthly payment	$
Term	Years
Debt service reserve fund	$

☐ Lease financing:

Capital or operating	$
Fair market value of leased assets at lease inception	$
Interest rate	%
Monthly payment	$
Term	Years

☐ Other financing alternatives:

Amount	$
Source (e.g., donated assets, etc.)	

B. Please provide copies of the following, if applicable: letter of interest from the lending institution, letter of interest from CHEFA, amortization schedule (if not level amortization) and the lease agreement.

14. Revenue, Expense and Volume Projections

A. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format:

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	0.00%	0.00%	0.00%	0.00%
Medicaid* (includes other medical assistance)	0.00%	0.00%	0.00%	0.00%
TriCare (CHAMPUS)	0.00%	0.00%	0.00%	0.00%
Total Government Payers	0.00%	0.00%	0.00%	0.00%
Commercial Insurers*	0.00%	0.00%	0.00%	0.00%
Self-Pay	0.00%	0.00%	0.00%	0.00%
Workers Compensation	0.00%	0.00%	0.00%	0.00%
Total Non-Government Payers	0.00%	0.00%	0.00%	0.00%
Uncompensated Care	0.00%	0.00%	0.00%	0.00%
Total Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

B. Provide the following for the financial projections:

i) A summary of revenue, expense and volume statistics, with the CON project, without the CON project and incremental to the CON project. **See attached.**

ii) The assumptions utilized in developing the projections (e.g., FTE's, volume statistics, other expenses, revenue and expense % increases, project implementation date, etc.).

iii) An explanation for any projected incremental losses from operations contained in the financial projections that result from the CON proposal.

15. Are you requesting a Waiver of Hearing pursuant to Section 19a-643-45 of OHCA's Regulations?

☐ Yes (if yes then check one:) ☐ Energy ☐ Fire Safety Code

☐ Non Substantive

☐ No

16. Project specific questions

For cardiac-specific applications only:

1. Identify how your proposal conforms with current professional guidelines (ACC?AHA, STS, etc.).

2. Provide recent literature (i.e. articles, journals, clinical trials, etc.) and/or data supporting your proposal.

For PET scanning applications only:

1. Provide the hours of operation of the mobile PET scanner at each proposed site.

2. Provide a copy of any written agreement or memorandum of understanding between the Applicant and the vendor. Include the proposed fee schedule and an explanation as to how the proposed fees were established.

3. (for mobile PET service) What services or personnel will the vendor be providing for the mobile PET scanner at each proposed hospital site?

4. Provide the current number of imaging procedures by procedure type currently being performed at the hospital (or by the Applicant).

5. What is the projected number of PET scans that will be used for specifically for detecting metastatic disease by each proposed hospital site? Will this use relate to a reduction in other imaging modalities?